

MEDICAL INFORMATION – DO YOU HAVE OR HAVE YOU EVER HAD...

Heart Disease: <input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Murmur: <input type="checkbox"/> YES <input type="checkbox"/> NO	Polio: <input type="checkbox"/> YES <input type="checkbox"/> NO
Respiratory Disease: <input type="checkbox"/> YES <input type="checkbox"/> NO	Premedicate: <input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis: <input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Disease: <input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis: <input type="checkbox"/> YES <input type="checkbox"/> NO	Any Broken Bones: ... <input type="checkbox"/> YES <input type="checkbox"/> NO
Liver Disease: <input type="checkbox"/> YES <input type="checkbox"/> NO	Type A B C (circle)	Prolonged Bleeding: . <input type="checkbox"/> YES <input type="checkbox"/> NO
Thyroid Disease: <input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes: <input type="checkbox"/> YES <input type="checkbox"/> NO	Yellow Jaundice: <input type="checkbox"/> YES <input type="checkbox"/> NO
H.I.V. Positive: <input type="checkbox"/> YES <input type="checkbox"/> NO	Anemia: <input type="checkbox"/> YES <input type="checkbox"/> NO	Radiation Therapy: ... <input type="checkbox"/> YES <input type="checkbox"/> NO
Venereal Disease: <input type="checkbox"/> YES <input type="checkbox"/> NO	Hemophilia: <input type="checkbox"/> YES <input type="checkbox"/> NO	Chemical Therapy: ... <input type="checkbox"/> YES <input type="checkbox"/> NO
Intestinal Disease: <input type="checkbox"/> YES <input type="checkbox"/> NO	Emphysema: <input type="checkbox"/> YES <input type="checkbox"/> NO	Blood Transfusions: .. <input type="checkbox"/> YES <input type="checkbox"/> NO
Bone Disease: <input type="checkbox"/> YES <input type="checkbox"/> NO	Mononucleous <input type="checkbox"/> YES <input type="checkbox"/> NO	Latex Allergy: <input type="checkbox"/> YES <input type="checkbox"/> NO
Nervous/Emotional Disease: <input type="checkbox"/> YES <input type="checkbox"/> NO	Asthma <input type="checkbox"/> YES <input type="checkbox"/> NO	Hay Fever: <input type="checkbox"/> YES <input type="checkbox"/> NO
High or Low Blood Disease: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Endocrine Problems: <input type="checkbox"/> YES <input type="checkbox"/> NO	Is the Patient Allergic to Anything? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Problems with Wounds Healing: <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, explain: _____	
Tumors or Cancer: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Rheumatic/Yellow/Scarlet Fever: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Acquired Immune Deficiency Syndrome (AIDS): <input type="checkbox"/> YES <input type="checkbox"/> NO	List Any Medications Being Taken: _____	
Is Patient Under Medical Care: <input type="checkbox"/> YES <input type="checkbox"/> NO		
A History of Fainting or Dizziness: <input type="checkbox"/> YES <input type="checkbox"/> NO		
A Drug Addiction: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Is the Patient Pregnant at this Time: <input type="checkbox"/> YES <input type="checkbox"/> NO	Are you aware of Any Other Disease, Condition, or Problem not listed above that	
Measles/Mumps/Chicken Pox: <input type="checkbox"/> YES <input type="checkbox"/> NO	We Should Know About? _____	
Does the Patient Smoke: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Is the Patient in Good Health: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Is Height and Weight Normal for Age: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Fever Blisters: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Has the Patient Had a Physical this Year: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Has the Patient Reached Puberty: <input type="checkbox"/> YES <input type="checkbox"/> NO	Are immunizations up to date? <input type="checkbox"/> YES <input type="checkbox"/> NO	

DENTAL HISTORY

Has the Patient Seen a General Dentist in the Last Year: <input type="checkbox"/> YES <input type="checkbox"/> NO	Does the Patient Have or Ever Had Any of the Following Habits:
Any Pain, Clicking or Discomfort In or Near the Ear: <input type="checkbox"/> YES <input type="checkbox"/> NO	Cheek, Tongue or Lip Chewing: <input type="checkbox"/> YES <input type="checkbox"/> NO
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident: <input type="checkbox"/> YES <input type="checkbox"/> NO	Thumb Sucking: <input type="checkbox"/> YES <input type="checkbox"/> NO
Have You Been Informed of Missing or Extra Permanent Teeth: <input type="checkbox"/> YES <input type="checkbox"/> NO	Mouth Breathing: <input type="checkbox"/> YES <input type="checkbox"/> NO
Are You aware of Any "Gum" Problems: <input type="checkbox"/> YES <input type="checkbox"/> NO	Finger Nail Biting: <input type="checkbox"/> YES <input type="checkbox"/> NO
Has a Physician or Dentist Advised Antibiotics Before Dental Exam: <input type="checkbox"/> YES <input type="checkbox"/> NO	Clenching Teeth: <input type="checkbox"/> YES <input type="checkbox"/> NO
Have the Patient's Tonsils or Adenoids Been Removed: <input type="checkbox"/> YES <input type="checkbox"/> NO	Tongue Thrusting: <input type="checkbox"/> YES <input type="checkbox"/> NO
Do You Feel the Patient Can Benefit from Orthodontic Treatment: <input type="checkbox"/> YES <input type="checkbox"/> NO	Grinding Teeth: <input type="checkbox"/> YES <input type="checkbox"/> NO
Is the Patient Happy with His/Her "SMILE": <input type="checkbox"/> YES <input type="checkbox"/> NO	Speech Problems: <input type="checkbox"/> YES <input type="checkbox"/> NO
Does the Patient Want to Improve His/Her "SMILE" and "BITE": <input type="checkbox"/> YES <input type="checkbox"/> NO	Has the Patient Been Examined by an Orthodontist Before: <input type="checkbox"/> YES <input type="checkbox"/> NO
Would the Patient Mind Wearing "BRACES" <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when: _____
Are you allergic to any metals or dental materials <input type="checkbox"/> YES <input type="checkbox"/> NO	Have other Members of the Family had Orthodontic Treatment: <input type="checkbox"/> YES <input type="checkbox"/> NO

In your own words, What Is The Orthodontic Problem: _____

What Would You Like Orthodontic Treatment To Accomplish? _____

Patient Signature

Date

Parent Signature